Health Services
LOS ANGELES COUNTY

Expected Practices

Specialty: Rheumatology

Subject: Approach to Spondyloarthritis

Date: May 20, 2014

Purpose:

Approach to the diagnosis and initial management of Spondyloarthritis

Target Audience: Primary Care Providers

Expected Practice:

When to think of Spondyloarthritis

The family of spondyloarthritis includes: ankylosing spondylitis, psoriatic arthritis, reactive arthritis, inflammatory bowel disease related arthritis, uveitis, undifferentiated and juvenile spondyloarthritis.

The typical patient is a young adult and gender non-specific. Generally, typical early symptoms involve back pain and/or enthesitis. The most important aspect of early diagnosis is in recognizing inflammatory back pain and arthritis.

Clinical Signs of Inflammatory Back Pain:

1. Responsive to NSAID's ATC
2. AM back stiffness
3. Improves with exercise
4. Age <40 with persistent back pain 3+ months
5. Insidious onset
6. No Relief at Rest
7. Pain at night
8. Alternating buttock pain

Associated Clinical Factors:

1. Enthesitis (inflammation of tendon and/or ligament insertion) on examination (typically at the insertion site of Achille's tendon) and dactylics ("sausage digit")
2. Sclerouveitis diagnosed by ophthalmologist
3. Psoriasis with arthritis
4. History of inflammatory bowel disease and arthritis

This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.

How to test for Spondyloarthritis

- Start by reviewing the clinical signs listed above. By obtaining a good history, 75% of patients will be captured correctly.
- Perform a thorough physical exam looking for enthesitis, psoriasis, dactylitis, sacroiliac tenderness.
- Send ESR and CRP.
- If evaluation consistent with inflammatory arthritis, consider radiographic imaging.
- If history and exam are suspicious for spondyloarthropathy, consider testing for HLA-B27; although this is not necessary prior to submitting eConsult.

All confirmed or suspected spondyloarthropathies should be referred to rheumatology via eConsult. eConsult to rheumatology should include the following: (1) A clear suspicion of inflammatory back pain and/or enthesitis by history and exam with (2) radiographic images if indicated showing inflammatory changes and/or (3) elevated inflammatory markers (ESR, CRP). HLAB27 does not necessarily need to be tested in order to eConsult for spondyloarthritis diagnosis/management.

Initial management of newly diagnosed Spondyloarthritis

NSAID's may have disease modifying properties for patients with ankylosing spondylitis and are used first line in therapy along with PPI. NSAID's that tend to be more effective are diclofenac 75mg BID and Indomethacin 50mg TID, and, if not GI tolerable, Celebrex 200mg BID. Standing dose of NSAID use for a 12 week period is acceptable for initial treatment prior to escalation of treatment regimen.

In conjunction with NSAID's and PPI, use of **sulfasalazine** is safe and may be effective in spondyloarthropathies (especially in AS and IBD associated arthritis conditions), and can be started at 500mg BID and titrated to 1500mg BID as a maximum dose.

Intermittent **corticosteroid** doses (i.e Medrol Pack or IM DepoMedrol at 1mg/kg) have been used to quell active and uncontrolled inflammation but are discouraged for chronic use (risks of osteoporosis, glaucoma, hypertension, etc).

Disease-modifying antirheumatic drugs (DMARDs) for RA like methotrexate and leflunomide (except in Psoriatic Arthritis with peripheral disease) do not seem to help reduce signs and symptoms and are generally not recommended for first line use.

References:
Rudalweit et al. The challenge of diagnosis and classification in early ankylosing spondylitis: do we need new criteria? Arthritis Rheum 2005; 52: 1000-1008